PROVIDER DEMOGRAPHIC SHEET

Name of POS Contact Person _____

Name of Exec. Director _____

Proposed Budget Dates _____ through _____

New Application _____

Renewal Application _____

1. Legal Name of Applicant Agency

2. Federal Employee Tax I.D. Number (Attach copy of last Form 990 if required by I.R.S.):

3. Name of Owner(s) and Address:

4. Business Mailing Address:

Street _____

City _____ State _____ Zip Code _____

Telephone: _____

Fax Number: _____ E-mail address: _____

5. Address where provider is located—Please attach list with all locations where services are provided if needed.

Street _____

City _____ State _____ Zip Code _____

Telephone: _____

Fax Number:_____ E-mail address: _____

6. Type of Provider (Check one):

Public

_____ Local Government
_____ State Government

Private

_____ Non-profit Corporation
_____ For profit Corporation
_____ Unincorporated for profit business

7. Is this facility approved to accept Medicaid reimbursement for Medicaid eligible clients?

Yes No

If so, indicate Service(s) and Medicaid rate approved:

_____

_____

8. *Current License(s) or Certification(s) now held: (Attach list, if necessary)

Issuing Authority _____

Date Approved _____ Expiration Date _____

Licensed Capacity _____

Other License(s) _____

Issuing Authority _____

Date Approved _____ Expiration Date _____

License Capacity _____

*ATTACH COPIES OF LICENSE(S) (AND ANY QUALITY ASSESSMENT(S) THAT HAVE BEEN ISSUED)

9. National Standards met by Applicant:

_____

_____

10. Enter the beginning and ending date for the following time periods used throughout this package:

Prior Year beginning date _____, ending date _____

Current Year beginning date _____, ending date _____

Proposed Budget beginning date _____, ending date _____

11. List the Cities and Counties and their corresponding FIPS codes for the area you serve.

12. List the local DRS field offices to whom you vend services.